

## PHARMACY COVERAGE GUIDELINE

### OFF-LABEL USE OF NON-CANCER MEDICATIONS

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#### **This Pharmacy Coverage Guideline (PCG):**

- Provides information about the reasons, basis, and information sources we use for coverage decisions
- Is not an opinion that a drug (collectively “Service”) is clinically appropriate or inappropriate for a patient
- Is not a substitute for a provider’s judgment (Provider and patient are responsible for all decisions about appropriateness of care)
- Is subject to all provisions e.g. (benefit coverage, limits, and exclusions) in the member’s benefit plan; and
- Is subject to change as new information becomes available.

#### **Scope**

- This PCG applies to Commercial and/or Marketplace plans
- This PCG does not apply to the Federal Employee Program, Medicare Advantage, Medicaid or members of out-of-state Blue Cross and/or Blue Shield Plans

#### **Instructions & Guidance**

- To determine whether a member is eligible for the Service, read the entire PCG.
- This PCG is used for FDA approved indications including, but not limited to, a diagnosis and/or treatment with dosing, frequency, and duration.
- Use of a drug outside the FDA approved guidelines, refer to the appropriate Off-Label Use policy.
- The “Criteria” section outlines the factors and information we use to decide if the Service is medically necessary as defined in the Member’s benefit plan.
- The “Description” section describes the Service.
- The “Definition” section defines certain words, terms or items within the policy and may include tables and charts.
- The “Resources” section lists the information and materials we considered in developing this PCG
- **We do not accept patient use of samples as evidence of an initial course of treatment, justification for continuation of therapy, or evidence of adequate trial and failure.**
- Information about medications that require prior authorization is available at [www.azblue.com/pharmacy](http://www.azblue.com/pharmacy). You must fully complete the [request form](#) and provide chart notes, lab workup and any other supporting documentation. The prescribing provider must sign the form. Fax the form to BCBSAZ Pharmacy Management at (602) 864-3126 or email it to [Pharmacyprecert@azblue.com](mailto:Pharmacyprecert@azblue.com).

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## Medical Necessity Requirements for Off-Label Use of Non-Cancer Medications

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### Criteria for Initial Therapy:

#### **Indication**

- Drug is requested for a non-cancer indication not approved by FDA (off-label)
- Drug must be FDA-approved for at least one other indication

#### **Age Requirement**

- Age consistent with manufacturer recommendations or FDA-approved labeling

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#### Baseline Clinical Evaluation

- Provider must submit diagnosis and treatment plan including rationale for off-label use
- Dose must be consistent with manufacturer recommendations or FDA-approved labeling
- Evidence that supports off-label use from **ONE** of the following:
  - American Hospital Formulary Service Clinical Drug Information with narrative text of “supportive”
  - IBM Micromedex DrugDex compendium meeting **ALL** of the following:
    1. Strength of Recommendation of Class I or IIa or IIb
    2. Strength of Evidence Category A or B
    3. Strength of Efficacy Class I or IIa
  - Elsevier Gold Standard’s Clinical Pharmacology compendium with narrative text of “supportive”
  - Wolters Kluwer Lexi-Drugs with use listed as “off-label, evidence level A”
  - Other authoritative reference as identified by the Secretary of the United States Department of Health and Human Services
  - At least **TWO** articles from major peer-reviewed professional medical journals supporting safety and effectiveness for the exception

#### Alternative Therapies

- Failure, contraindication, intolerance to **TWO** or more other FDA-approved medications that are on the formulary

#### Brand Specific Criteria

- Have failure, contraindication, or intolerance with **THREE** generic equivalents (when available) for at least three months each. **Note:** Any failure, contraindication, or intolerance to the generic drugs should be reported to the United States Food and Drug Administration (FDA) (see Definitions section)

#### Safety

- No FDA-labeled contraindications for use of the requested drug
- No significant exclusions to use of the requested drug as outlined in product label (e.g., medical conditions, warnings or precaution for kidney dysfunction, hepatic dysfunction, other)
- No significant interacting drugs

#### Additional Requirements

- There are no benefit or contract exclusions that apply

#### Documentation Requirements

- A completed request form must be submitted, including:
  - Chart notes
  - Lab results
  - Supporting clinical documentation

#### Initial Therapy Criteria Approval Duration

- 6 months OR end of plan year

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#### Criteria for Continuation of Therapy (renewal therapy)

**Note: Manufacturer assistance (e.g., coupons, samples, etc.) are not considered for continuation of therapy**

##### Clinical Response

- No evidence of disease progression
- Documented evidence of efficacy, disease stability and/or improvement

##### Adherence

- Adherence to the prescribed therapy regimen has been documented

##### Brand Specific Criteria

- Have failure, contraindication, or intolerance with **THREE** generic equivalents (when available) for at least three months each. **Note:** Any failure, contraindication, or intolerance to the generic drugs should be reported to the United States Food and Drug Administration (FDA) (see Definitions section)

##### Safety

- No new contraindications or significant adverse drug effects
- No significant exclusions to use of the requested drug as outlined in product label (e.g., medical conditions, warnings or precaution for kidney dysfunction, hepatic dysfunction, other)
- No significant interacting drugs

##### Additional Requirements

- There are no benefit or contract exclusions that apply

##### Documentation Requirements

- Chart notes
- Supporting clinical documentation with evidence of improvement in given indication
- Lab values that confirm safe use from above criteria

##### Continuation Therapy Criteria Approval Duration

- 12 months OR end of plan year
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#### Criteria for Off-Label Use Requests:

**Criteria when use is considered experimental or investigational:** The exception request is considered **experimental or investigational** when any **one or more** of the following criteria are met:

1. Lack of final approval from the appropriate governmental regulatory bodies (e.g., Food and Drug Administration); or
2. Insufficient scientific evidence to permit conclusions concerning the effect on health outcomes; or
3. Insufficient evidence to support improvement of the net health outcome; or
4. Insufficient evidence to support improvement of the net health outcome as much as, or more than, established alternatives; or
5. Insufficient evidence to support improvement outside the investigational setting.

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These indications include, *but are not limited to*: Treatment with dosing, frequency, or duration outside the FDA-approved dosing, frequency, and duration.

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#### **Description:**

For FDA approved indication(s), also known as labeled indication(s), the FDA has reviewed and approved the medication for the specified use(s) for marketing based on adequate, well-controlled clinical trials, which have documented safety and effectiveness. The use of an FDA approved medication for conditions, indications or in circumstances other than those approved by the FDA is known as “off-label use” (also referred to as unapproved use or unlabeled use). Unapproved or unlabeled uses include a variety of situations ranging from completely unstudied uses to scientifically investigated uses where the manufacturer has not asked the FDA for formal approval.

Off-label use of medications that have previously received FDA approval for marketing may be reviewed in any of the following ways: for medical necessity and/or investigational uses; during a review of a medication that requires prior authorization; during review of a medication due a non-formulary request for coverage; or during a review for any other prescription limitations.

An approved NDA (New Drug Application), ANDA (Abbreviated New Drug Application), or BLA (Biologic License Application) is considered final FDA-marketing approval for the purposes of this policy.

In certain instances, scientific evidence may support using a drug to treat a disease even if the drug's FDA approved label does not include those clinical conditions. In these circumstances, a compendium or scientific peer-reviewed literature specific for the indication in question may recommend uses beyond those included in the FDA approved labels. A compendium is a comprehensive listing of FDA approved drugs and biologics. Compendia include a summary of how each drug works in the body, as well as information for health care practitioners about proper dosing and whether the drug is recommended or endorsed for use in treating a specific disease.

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#### **Definitions:**

U.S. Food and Drug Administration (FDA) MedWatch Forms for FDA Safety Reporting  
[MedWatch Forms for FDA Safety Reporting | FDA](#)